BUDGET HIGHLIGHTS

- **Substance Abuse and Mental Health Services Administration (SAMHSA)—Access to Recovery: up $100.6 million.** The President has committed to expand the drug treatment system over five years, including through the Access to Recovery initiative (ATR). The fiscal year 2005 budget proposes $200 million for ATR, an increase of $100.6 million over the 2004 enacted level.

    - This initiative will provide people seeking clinical treatment or recovery services with vouchers to pay for the care they need. Vouchers may be redeemed for services at eligible organizations, including those that are faith based, and will allow more flexible delivery of services to individuals based on their treatment need.

- **Office of Justice Programs—Drug Courts Program: up $32 million.** The Administration recommends a funding level of $70.1 million for the drug courts program in fiscal year 2005. This represents an increase of $32 million over the 2004 enacted level. This enhancement will increase the scope and quality of drug court services with the goal of improving retention in, and successful completion of, drug court programs. Funding also is included to generate drug court program outcome data.

    - The drug courts program provides alternatives to incarceration, using the coercive power of the court to force abstinence and alter behavior by drug-dependent defendants with a combination of clear expectations, escalating sanctions, mandatory drug testing, treatment, and strong aftercare programs.

- **National Institute on Drug Abuse (NIDA): up $28.3 million.** This increase will ensure NIDA's continuing commitment to key research efforts, including basic research on the nature of addiction, development of science-based behavioral interventions, medications development, and the rapid translation of research findings into practice.

    - NIDA's efforts include: the National Prevention Research Initiative, Interventions and Treatment for Current Drug Users Who Are Not Yet Addicted, the National Drug Abuse Treatment Clinical Trials Network, and Research Based Treatment Approaches for Drug Abusing Criminal Offenders.

Healing America's Drug Users: Getting Treatment Resources Where They Are Needed

The Strategy uses the public health model as a way to understand the epidemiology of drug use and control its spread. The public health model is the only understanding of addiction that can explain why people continue to use drugs when the consequences are a devastating disease of the brain and a terrible loss of human potential.

Conventional wisdom on the topic suggests that young adults use drugs because they think they are invincible. Adults, presumably wiser but also self-destructive or simply optimistic, are thought to recognize the dangers but use drugs anyway. They watch an addict and tell themselves that things will be different for them.

But the conventional wisdom only explains so much. Why, for instance, do people initiate the use of methamphetamine—a drug that can cause a complete unraveling of home life, work, and social connections in a matter of months?

The public health model suggests a deeper explanation, one touched upon in the previous chapter's discussion of prevention and the role of newly drug-using teens in proselytizing their peers to join in the fun, and seeking to normalize their own drug using behavior. Simply put, many people use drugs because they know someone who is using and not suffering any apparent consequences. The disease of drug dependence spreads because the vectors of contagion are "asymptomatic" users who do not yet show the consequences of their drug habit, and who do not have the slightest awareness of their need to seek help.

It is especially important to intervene with users during this "honeymoon" phase. A new approach suggests a way ahead, using the existing medical infrastructure—which already has extensive experience in identifying problem drinkers—to screen for drug use and offer appropriate and often brief interventions. The Department of Health and Human Services has awarded seven grants in the past year to advance our understanding of screening and brief intervention in treatment. In Chicago, for example, Cook County Hospital emergency room staff as well as doctors and nurses in other areas of the hospital will be trained to detect the signs of developing drug use and direct users into treatment.

Expanding Access to Recovery

Screening and brief interventions hold promise for cutting short the drug problems of millions of Americans. Yet 20 million Americans are past-month, or current, users of at least one illegal drug, and seven million Americans need drug treatment, according to diagnostic criteria developed by the American Psychiatric Association.

More than one million Americans receive treatment each year and start on the road to recovery. In recent years, however, an average of 100,000 of those who seek treatment each year

have not been able to receive it. They have an immediate need, and we have launched a new program to address it—Access to Recovery. Begun in fiscal year 2004, with an additional $100 million requested in fiscal year 2005, the program will expand access to clinical substance abuse treatment, including recovery support services, while encouraging accountability in the treatment delivery system.

The program will work as follows: Those without the means to pay for treatment will be assessed and issued a voucher for the cost of treatment or recovery services as appropriate.

Recognizing that there are many routes to recovery, this initiative envisions a pathway to help that is direct and open on a nondiscriminatory basis to all, including services provided by faith-based organizations. For many Americans, the transforming powers of faith are crucial resources in overcoming dependency, and this new program will work to ensure that treatment vouchers are available to the programs that work the best, including those that are faith-based (see box below).

From Waiting to Denial

Most policy analyses of drug treatment begin and end with a discussion of waiting lists. Although such lists are a staple of journalistic accounts of the drug treatment system, even the roughly 100,000 individuals seeking but unable to obtain treatment represent a tiny fraction—perhaps one in 70—of the number in need of help. The real problem is that a much larger number of Americans—some six million—are dependent on an illicit drug and

KEY ELEMENTS OF ACCESS TO RECOVERY:

- *Flexibility*. With a voucher, people in need of treatment or recovery support services will have the freedom to select the programs and providers that will help them most—including programs run by faith-based organizations.

- *Results Oriented*. Grantee institutions will be asked to develop systems to provide an incentive for positive outcomes.

- *Increased Capacity*. Access to Recovery is projected to support treatment or recovery support services for approximately 100,000 people per year.

are not seeking treatment (see Figure 7). Thus the central problem is not waiting lists, but waiting for individuals who are in denial about their need for drug treatment to recognize that need.

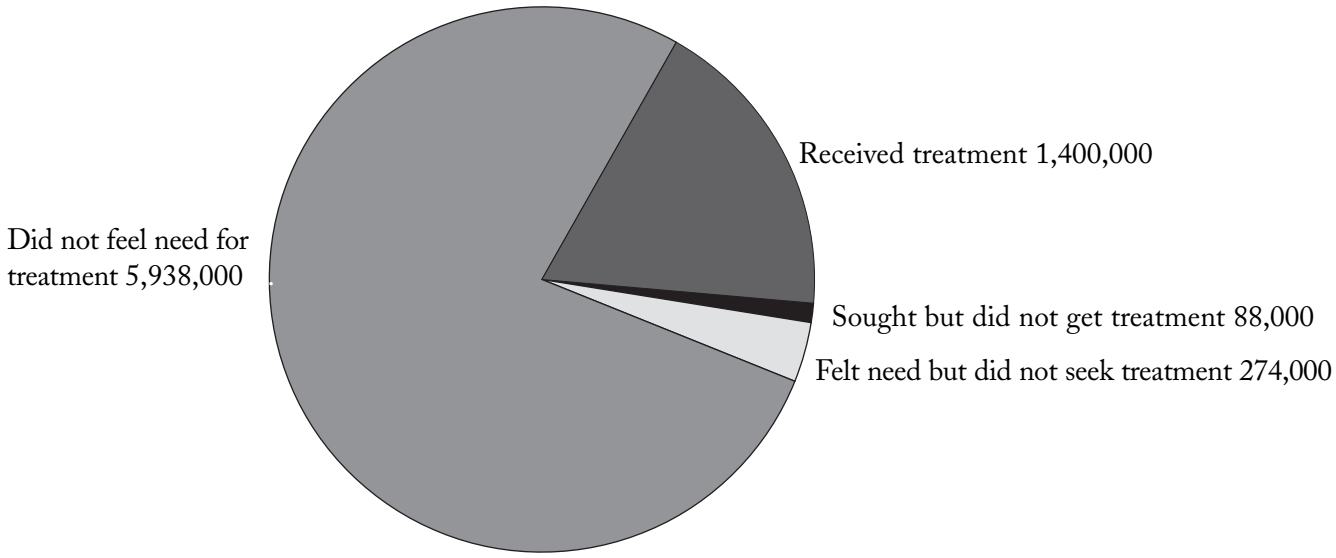
A voucher system, for the first time, offers those seeking drug treatment a consumer-driven path to the services they need; yet, the larger challenge for our society is to direct drug-dependent individuals—one in five of whom also suffers from a serious "co-occurring" mental illness—to the help they so desperately need but fail to consider.

Closing this "denial gap" is a vast undertaking. Helping our brothers and sisters in need and staring down the social discomfort and risk of alienation to offer the hope of recovery requires the energy and commitment of all Americans. We must create a climate in which Americans confront drug use honestly and directly, offering the compassionate coercion of family, friends, and the community, including colleagues in the workplace, to motivate the change that brings recovery.

When such efforts fail, and when individuals run afoul of the criminal justice system, we must make all reasonable efforts to identify and direct individuals in need into court-supervised drug treatment. In this connection, the Administration has requested a $32 million increase in Federal support for the drug courts program in fiscal year 2005.

Drug courts use the authority of a judge to require abstinence and altered behavior through a combination of clear expectations, graduated sanctions, mandatory drug testing, case management, supervised treatment, and aftercare programs—a remarkable example of a public health approach

Figure 7: Most of Those in Need of Drug Treatment Do Not Seek It



Source: National Survey of Drug Use and Health, 2002

linked to a public safety strategy. Carefully modulated programs like drug courts are often the only way to free a drug user from the grip of addiction. More than 1,183 drug courts operate in all 50 states, with an additional 414 courts in the planning stages (see Figure 8 on page 26).

Focus on Prescription Drug Safety

Traditional drug threats involve illicit substances grown or produced abroad and smuggled across America's borders by traffickers. By contrast, with few exceptions, prescription drugs are legal medicines, legitimately manufactured, distributed by licensed pharmacists, and prescribed in good faith by physicians. And while most Americans understand the risks of addiction or even death from drugs like heroin or cocaine, they are less likely to appreciate the risks associated with prescription drugs, which are approved and certified by the government. Yet, through negligence, theft, fraud, or forgery, these addictive substances are being diverted and abused with alarming frequency.

Surveys confirm that the nonmedical use of prescription drugs has emerged in the last decade

OPERATION PAR'S THERAPEUTIC COMMUNITY WITH A DIFFERENCE

Operation PAR (Parental Awareness and Responsibility) got its start the way many effective programs do: a parent concerned about her child's drug use took action. That parent was Shirley Coletti. The west central Florida-based nonprofit she founded in 1970 has grown to more than 625 employees in four counties serving 9,800 individuals a year, from juvenile felons to outpatient heroin addicts on methadone maintenance.

One of the group's many remarkable programs is PAR Village, a residential, therapeutic community-type drug treatment campus spread over three acres. At PAR Village, 25 to 30 mothers and expectant mothers spend up to 18 months living with their young children. Another 20 mothers with older children live alone but can have their children stay overnight.

The program grew out of in-house research. As Nancy Hamilton, Operation PAR's CEO, explains, "We studied the question of whether mothers did better if they were able to keep their children [while] in treatment," says Hamilton. "We found that they did."

Some of the women at PAR Village are at risk of losing their children and come as a condition of maintaining parental rights. Some have been sentenced by a drug court

as a major problem. The illegal diversion, theft, and medical mismanagement of prescription drugs (particularly opioid pain medications) have increased and, in some areas, present a larger public health and law enforcement challenge than cocaine or heroin.

According to the most recent National Survey of Drug Use and Health, the misuse of psychotherapeutic drugs—pain relievers, tranquilizers, stimulants, and sedatives—was the second leading category of illicit drug use in 2002, following marijuana. An estimated 6.2 million Americans (approximately 2.6 percent of the population age 12 and older) had used a psychotherapeutic drug for nonmedical reasons in the month prior to the survey.

The bulk of this abuse involves narcotic analgesics—an estimated 4.4 million Americans are past-month (so-called current) nonmedical users of pain relievers. OxyContin, a powerful time-release painkiller with an addiction potential similar to morphine, was used nonmedically at least once by 1.9 million Americans in 2002. The rate of OxyContin abuse in 2002 was ten times higher than in 1999.

The University of Michigan's Monitoring the Future survey for 2003 finds a similar pattern among young people, with the nonmedical use of prescription drugs second only to marijuana. The abuse by high-school seniors of the brand-name narcotic Vicodin is more than

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but are given a chance to have their children join them.

Drug use by parents and its effects on children are treated simultaneously. "You have two clients—the mom and the child," says Hamilton. "While you are doing treatment with the mom, you are doing prevention with the child."

Many of the women who enter PAR Village are hard cases, but Hamilton is impatient with treatment providers who take only the most promising clients. "A lot of programs explain their failures by saying that they just need a better class of clients. We think there's no such thing as client failure—only program failure."

"These moms come in and they are pretty much unsuccessful in every area of their lives," says Hamilton. "And they come in here and we create an environment where they can be successful. But it's not easy. Our counselors and staff have to teach them how to bathe their kids, how to feed their kids dinner, how to put the kids to bed. We tell the nurses who want to work here that they have to be prepared for the unexpected."

The unexpected sometimes has to do with clarifying the line between discipline and abuse. "Often, we have to teach parents how to discipline their children without being abusive," says Hamilton. "But it is a joy to watch children flourish as their recovering mothers learn better parenting skills and as their recovering mothers learn to give them the greatest gift of all—the time that drugs used to occupy."

double their use of cocaine, Ecstasy, or methamphetamine. This drug has become a deadly youth fad, with one out of every ten high-school seniors reporting nonmedical use. Some 5 percent of seniors report nonmedical use of OxyContin.

ONE-STOP SHOPPING AT NASHVILLE'S DRUG COURT

Judge Seth Norman spent five years as a criminal court judge in Nashville before tiring of the parade of familiar faces and deciding to try something different. "I saw the same person coming through the door time and time again," says Judge Norman. He and colleagues investigated the possibility of securing funding for a drug court, and even after being awarded a Federal grant, found that he still had to scrounge for furniture.

"I took five guys out of jail," says Judge Norman. "I took them to an abandoned state mental hospital—it was in terrible shape—and I told them that if they'd clean it up, I'd find them some counseling."

Eight years later, the Davidson County Drug Court is nationally known as much for its impressive results as for its unusual approach. In the reverse of the usual pattern, the drug court refers the majority of its clients not to outpatient treatment but to an intensive, year long residential treatment regimen known as a therapeutic community.

"Most of the people we deal with have serious enough problems that they are going into inpatient treatment," says Judge Norman. "Drugs like crack cocaine are just so potent that [users] are going to have to spend some time in treatment before they are going to be better." The remainder, less than 20 percent of referrals, is assigned to outpatient treatment with weekly hearings and regular drug testing.

The drug court is unusual for another reason: the inpatient therapeutic community to which it refers clients, which houses up to 100 long-term residents, is co-located with the drug court. Supervision is intense. "The Judge and the treatment counselors know all of the residents by name," says Jeri H. Bills, the court's program coordinator. "People here learn to be responsible—and these people have never had any responsibility. They've never had a job, paid taxes, gotten up early to walk their kids to the school bus. Here, they get up every day before six, they run the place, they keep the grounds."

The program comprises three phases, an acclimation phase for roughly the first six to eight weeks is followed by six to eight months during which residents have minimal freedom of movement. They can earn passes to leave for four hours at a

Additionally, according to the Drug Abuse Warning Network (DAWN), a nationwide sentinel system that monitors drug-related emergency room episodes, nonmedical use of narcotic analgesics as a reason for an emergency room visit rose 163 percent between 1995 and

time, with the understanding that they will be drug tested on their return.

To enter the third and final phase, residents must find work. "We provide all residents with a bus pass," says Judge Norman, "and we coach those with literacy issues, but they have to go out and find their own job." One-third of residents' pay goes back into the program to cover costs, one-third goes to a savings account to provide some stability when residents return to the outside world, and one-third goes to court-related costs such as child support and restitution to victims.

Keeping a job for 90 days is one requirement for "coining out" (graduates get a commemorative coin on graduation from the residential portion of the program). Coining out is followed by another six months of supervision while clients reintegrate into society.

Recidivism—here defined as being convicted of any crime after graduation—is about 18 percent. "We take each of our 260 graduates and we run them through an NCIC [National Crime Information Center] check and a local police arrest query," says Judge Norman. Not that the program's graduates are all that hard to track down. An alumni association meets in the courtroom every other Tuesday night.

The program's graduation rate is about 65 percent. "Some people come in and just say 'to heck with this—I'll just do my 10 years,'" says Judge Norman. "Many of them have done time so many times that for them, it's just another trip to prison. Here, you're not going to find a boom box or a TV. You have to do exactly what you are told to do, when you are told to do it. And you know what? These folks find that they love having some structure in their lives."

Judge Norman and the drug court staff feel strongly about the supportive role family members can play in a resident's recovery. "We don't push it until midway through phase two," says Jeri Bills. "The family wants to help the person, but often they haven't known what to do. Having them there says that the person in treatment is not doing it on their own—they have the support of a family that has probably been alienated for so long."

Judge Norman still has his day job in the criminal court, but he looks forward to the time he spends in drug court. "It's just about one of the most satisfying things a person can do is see a person become a successful citizen after they have been addicted to drugs for many years."

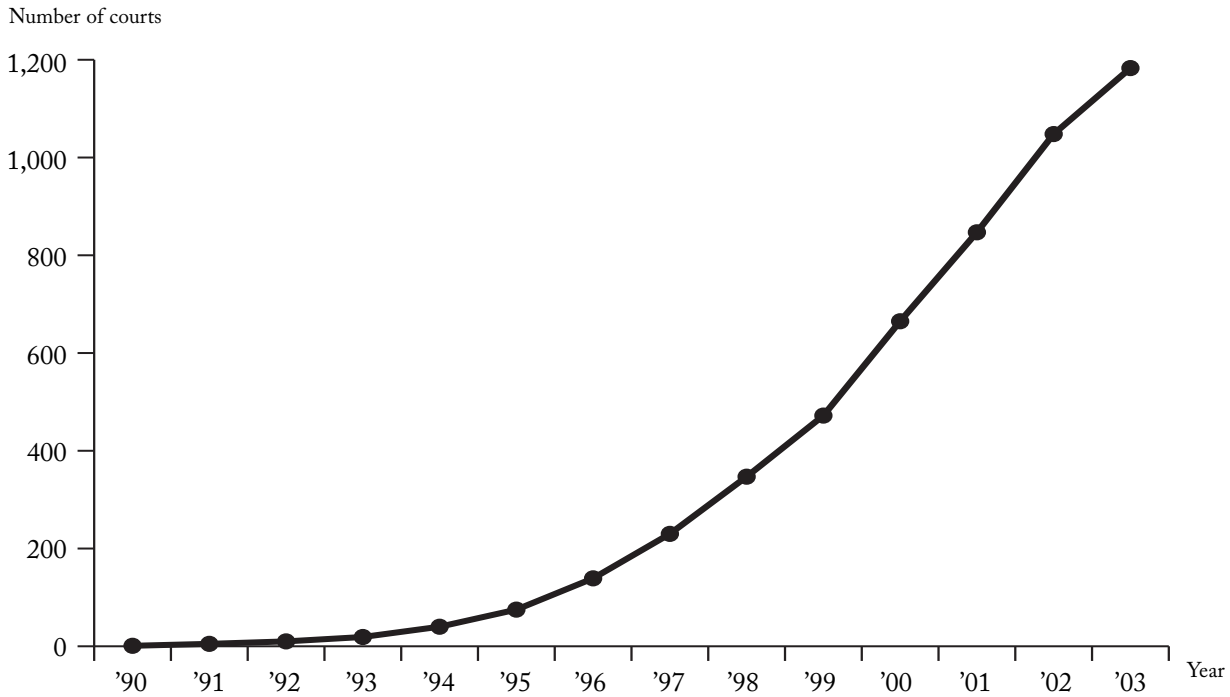
2002. More alarming, trend data from DAWN for the years 1995–2002 shows a dramatic rise in emergency room mentions of single-entity oxycodone (formulations of the narcotic without other drug combinations), from 100 mentions in 1996 to nearly 15,000 mentions in 2002.

Curtailing Doctor Shopping

Pharmaceuticals can be diverted in multiple ways. The most popular form of diversion is known as doctor shopping—visiting many doctors to acquire large amounts of controlled substances. Other diversion methods focus on the pharmacies themselves, which may experience theft or inappropriate distribution of controlled drugs by pharmacists or employees or may receive forged prescriptions. Physicians may inappropriately prescribe controlled substances through either insufficient risk-management of patients with a potential for abuse or outright fraudulent medical practice. Those who acquire diverted substances may themselves abuse them or sell them to others at enormous profit.

The most alarming form of prescription drug abuse involves substances classified under the Controlled Substances Act as Schedule II or III drugs. By definition, these drugs have a high

Figure 8: Number of Drug Courts Nationwide



Source: National Drug Court Institute

potential for abuse, but also an accepted medical use. Simply to ban such substances would undermine the legitimate medical purposes that they serve and would increase the suffering of many. The challenge for policymakers is to suppress the abuse of prescription drugs without infringing unnecessarily on legitimate medical practice.

The Federal Government has sophisticated systems in place for tracking and controlling drugs with high potential for abuse, from the manufacturer down to the wholesale level. The Drug Enforcement Administration (DEA) has regulatory and investigative jurisdiction over the diversion of controlled pharmaceuticals, and accomplishes its control and monitoring functions through a nationwide database. As a result, relatively little of the diversion problem originates in the manufacturing-to-wholesaling system.

It is at the retail level, the most frequent site of diversion, where the need for increased monitoring is greatest. We are now closing this gap in part through the development of something most Americans assume already exists—state-level prescription monitoring programs. PMPs, as they are known, are designed to facilitate the collection, analysis, and reporting of information on the prescribing, dispensing, and use of pharmaceuticals.

The data generated by PMPs is analyzed by licensing, regulatory, or law enforcement agencies to track a patient's use of prescription medicines. When cases of inappropriate prescribing or

FIGHTING PRESCRIPTION DRUG ABUSE AT THE STATE LEVEL

In Nevada, pharmacies are required to download prescription information to the state's Prescription Controlled Substance Abuse Prevention Task Force, which sifts through the data to identify doctor shoppers. The Task Force then sends informational letters to each of the patient's practitioners and pharmacies asking them to intervene, referring the patient to appropriate treatment or counseling.

The program has had the added benefit of encouraging both practitioners and pharmacies to recognize the potential doctor-shopping problem and encourages them to review their patients' drug history, soliciting reports instead of waiting to be contacted. When the program began in 1997, the task force received 480 such requests for reports; by 2003 this number had risen to 13,925.

The benefits of the program have far outweighed its annual $131,000 budget. Nevada instituted the system in 1997, and in just the first year alone, the number of narcotic drug doses dispensed to suspected abusers was cut by 46 percent—a result typical of other states' experiences.

dispensing of controlled substances appear, regulatory and law enforcement officials are alerted. PMPs also offer physicians a way to obtain information on whether their patients or prospective patients have obtained the same or similar prescription drugs from other doctors.

State programs like these do not interfere with legitimate prescribing and dispensing of pharmaceuticals. Nor do they violate patient confidentiality requirements. Currently, 21 states have some form of reporting mechanism, with additional states in the development stage.

The effectiveness of PMPs can be seen in a simple statistic: in 2000, the five states with the lowest number of OxyContin prescriptions per capita all had PMPs. According to DEA, the five states with the highest number of prescriptions per capita all lacked them.

An important feature of successful PMPs is developing the authority to share data across state lines to combat border-crossing abusers trying to avoid detection. The startup cost of a PMP is surprisingly modest—approximately $300,000 per state, with most states able to operate them continually for between $150,000 and $1 million per year. Internet monitoring tools are essential for establishing an effective system. DEA is also currently developing a method to track and monitor illegitimate Internet prescription offers.

Prescription monitoring programs offer real hope for effective diversion control and restoring prescription safety, but they cannot succeed in isolation. The pharmaceutical industry itself must become a part of this partnership in a constructive way. Manufacturers must commit to responsible advertising and risk announcements involving their products.

The Food and Drug Administration (FDA) will continue to monitor promotional materials for controlled substances, particularly for sustained-release products, to ensure that false and potentially misleading claims are not made. The FDA Office of Criminal Investigations is working with DEA on investigations involving the illegal sale, use, and diversion of controlled substances, including illegal sales over the Internet. DEA will improve its training on the recognition and pursuit of diversion cases so that they can pursue cases aggressively without limiting proper pain management by physicians.

Finally, physicians must perform risk assessments on patients at risk for potential abuse. This is particularly true for patients entering opiate therapy for chronic pain. Physician licensing boards must insist on more effective education for future doctors, and on remedial courses in risk management and awareness of dangerous new drugs for existing practitioners. State licensing boards must exercise appropriate oversight and take action against physicians who undermine the integrity of medical practice.